Date:
Worker:

Telephone:
BG #:
HH #:
Case Name:

South Carolina Medicaid Program
Annual Review Form

This form is used to review your Medicaid coverage.

You must return this form to us by: _____

- If you do not return this form, your Medicaid will stop. This could affect the amount of your Social Security benefit.
- If you do not return proof of your income and resources, we cannot continue your Medicaid.
- Please fill out EACH item on this form.
- If an item does not apply, write "does not apply."
- If an answer to any question is none or 0, write "none".

If you need help filling out this form, call your worker listed above.
Si necesita ayuda para llenar este formulario, puede llamar a su trabajador cuyo nombre aparece arriba.

What language do you use most? ☐ English ☐ Spanish ☐ Other (specify) _____

1. Fill out the following information about yourself:

Last Name	**First Name**			**Middle Initial**
Mailing Address (Include Apartment/Lot Number)	**City**	**County**	**State**	**Zip Code**
Street Address, if different (Include Apartment/ Lot Number)	**City**	**County**	**State**	**Zip Code**
Telephone Number where we can reach you, including area code **Phone #** ( ) **Second Phone #** ( )			**FOR AGENCY USE** Date Received:	

If an Authorized Representative is completing this application, please complete the following:
Name: _____ Phone Number:_____
Address: _____ Relationship: _____
_____

2. Tell us who lives with you. List yourself first.

Name	Social Security Number	Date of Birth	Check all that apply	How is this person related to the beneficiary?
			☐ US Citizen ☐ Disabled ☐ Pregnant	SELF
			☐ US Citizen ☐ Disabled ☐ Pregnant	☐ Child ☐ Spouse ☐ Other: _____
			☐ US Citizen ☐ Disabled ☐ Pregnant	☐ Child ☐ Spouse ☐ Other: _____
			☐ US Citizen ☐ Disabled ☐ Pregnant	☐ Child ☐ Spouse ☐ Other: _____

Give us the name of any family members who have moved OUT of your home in the past year: _____

Please fill out the following for all family members who have moved IN your home in the past year.

Name:		**Social Security Number**:	**Full Name at Birth**:	**Mother's Full Name at her Birth**:
Is this person applying for Medicaid? ☐ Yes ☐ No	**Sex**: ☐ Female ☐ Male	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**Date of Birth:**	**County/State of Birth:**
Medicare Number, if applicable:		**Race**: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other		

Name:		**Social Security Number**:	**Full Name at Birth**:	**Mother's Full Name at her Birth**:
Is this person applying for Medicaid? ☐ Yes ☐ No	**Sex**: ☐ Female ☐ Male	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**Date of Birth:**	**County/State of Birth:**
Medicare Number, if applicable:		**Race**: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other		

3. Does anyone in your family work? ☐ Yes ☐ No

Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks**.

Your Income from Employment	**Other Parent/Spouse Income from Employment** (*if living in the home)*
Name of person employed _____	Name of person employed _____
Employer's Name _____	Employer's Name _____
Employer's Address _____	Employer's Address _____
_____	_____
Employer's Phone Number (including area code) _____	Employer's Phone Number (including area code) _____
Gross amount earned per pay period? $_____	Gross amount earned per pay period? $_____
How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
still employed? ☐ Yes ☐ No If no, where did you work last?	still employed? ☐ Yes ☐ No If no, where did you work last?
_____	_____
When did you stop working there? _____	When did you stop working there? _____

Is anyone self-employed? ☐ Yes ☐ No If yes, please name Self-Employment Business and/or Partnership_____

_____

You must send copies of all the most recently filed Federal income tax forms with all schedules.

4. Please list below ANY money received. You must send proof of income received in the past 4 weeks.

Other Income	**Amount**	**Which family member gets this income?**	**How often is this income received?**
Child Support	$		
Alimony	$		
Social Security Income	$		
Unemployment Benefits	$		
Veterans Benefits	$		
Workers Compensation/Long Term or Short Term Disability	$		
Cash Contributions	$		
Retirement/Pensions/Annuities	$		
Other Income (*Please Explain)*	$		

5. Does anyone in your family have any assets or resources like those listed below? ☐ Yes ☐ No You must send proof of the value of each.

Asset/Resource	Yes	No	Company name, address, and phone #; Account/Policy number; and/or Description	Who does it belong to?	What is the value?	How much is owed?
Cash on Hand					$	
Checking Account(s)					$	
Savings Account(s)					$	
Certificate(s) of Deposit					$	
Annuities/Trusts/Stocks/ Bonds					$	
Home Property (location/description)					$	$
Other Property (location/description)					$	$
Life/Burial insurance					$	$
Burial Contracts					$	$
Burial Plots					$	$
Vehicles (make, model, year)					$	$
Retirement Account					$	$
Other (please be specific)					$	$

6. Have you added or dropped any private health insurance or long-term coverage that covers medical expenses? ☐ Added ☐ Dropped

If added or dropped: Name of Insurance_____.

If added, please send a copy of the insurance card (front and back). Do not include Medicare or Medicaid.

If dropped, please send a copy of the termination letter.

7. Does anyone pay for child care (or care for a disabled adult) to be able to go to work or school?

☐ Yes ☐ No If **Yes**, you must send proof of the payment(s).

IMPORTANT

Did you remember to attach the information that we need to complete your Annual Review?

- ☐ **Proof of your earnings**
- ☐ **Proof of other income**
- ☐ **Proof of assets or resources**

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Partners for Health Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).

   a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.

   b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

3. I know that my Social Security Number, which I am required to provide, under §1137(a) (1) of the Social Security Act [42 U.S.C. 1320b-7(a) (1)], may be used or released in connection with the exceptions in Item 2, above.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.

7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

8. I know that I may request a hearing if I believe an error has been made in processing my application.

☐ **I have read the Rights and Responsibilities, or they have been read to me.** *(If possible, both the Applicant and Authorized Representative should sign.)*

Applicant's Signature: _____ Date: _____

Authorized Representative's Signature: _____ Date: _____